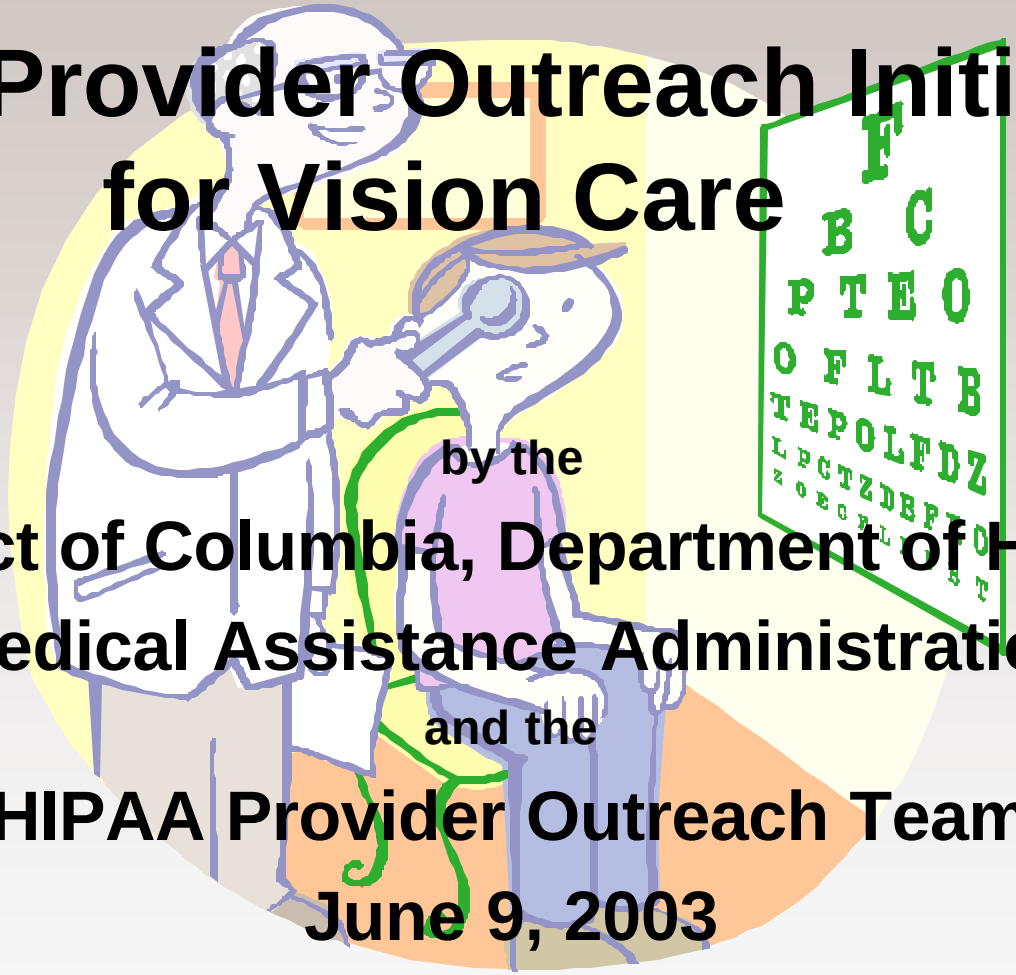
HIPAA Provider Outreach Initiative for Vision Care



by the

District of Columbia, Department of Health, Medical Assistance Administration

and the

HIPAA Provider Outreach Team

June 9, 2003

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Today's Agenda

- **HIPAA Overview**
- **New Vision Care Billing Policy**
- **Electronic Data Interchange**

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HIPAA Overview

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Objective

- Overview
  - Administrative Simplification
    - Background
    - Goals
    - Benefits
    - HIPAA Rules

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Background

- **Health Insurance Portability & Accountability Act**
  - **Portability**
    - **Insurance Reform**
  - **Accountability**
    - **Criminal and Civil Penalties**
  - **Administrative Simplification**
    - **Health Care Transactions and Code Sets**
    - **Privacy**
    - **Security**
    - **National Identifiers**

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Administrative Simplification

- **Goals**
  - **Increase the use and efficiency of electronic methods of exchanging standard health care information**
  - **Reduce the number of forms, the methods of completing claims, and other health care related documents**

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Administrative Simplification

- **Benefits**
  - **Lower administrative costs**
  - **Enhance accuracy of data and reports**
  - **Increase provider satisfaction**
  - **Reduce processing time and improving cash management**

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Administrative Simplification

Regulation	NPRM Published	Final Rule Published	Compliance Deadline
Transactions & Code Sets	05/07/98	08/17/00	10/16/03
Privacy	11/03/99	12/28/00	04/14/03
National Employer Identifier	06/16/98	05/31/02	07/30/04
Security	08/12/98	2/20/03	04/21/05
National Provider Identifier	05/07/98		

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Administrative Simplification

Regulation	NPRM Published	Final Rule Published	Compliance Deadline
National Individual Identifier			
National Health Plan Identifier			
Claims Attachment			
Enforcement	5/19/03-5/24/03		

Not Published

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Administrative Simplification

- **Standardized Transaction Sets**
  - **ANSI ASC X12N 837 = Health Care Claim (P, I, and D)**
  - **ANSI ASC X12N 835 = Health Care Claim Payment/Advice**
  - **ANSI ASC X12N 270 = Health Insurance Eligibility Request**
  - **ANSI ASC X12N 271 = Health Insurance Eligibility Response**
  - **ANSI ASC X12N 276 = Health Care Claims Status Inquiry**
  - **ANSI ASC X12N 277 = Health Care Claims Status Response**
  - **ANSI ASC X12N 278 = Health Care Claims Service Referral/Authorization**

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Administrative Simplification

- **Code Sets**
  - **Nationally developed diagnosis and procedure codes**
    - **CPT, HCPCS, and ICD-9**
  - **Non-medical code sets detailed in the implementation guides**
  - **Must be used in all applicable standard transactions**
  - **No local codes**

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Administrative Simplification

- **Privacy Rule-April 14, 2003**
  - **An individual's rights to control access and disclosure of their protected or individually identifiable health care information.**
  - **Objectives of the Privacy Rule:**
    - **Give patients more control**
    - **Establish appropriate safeguards**
    - **Hold violators accountable**

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Administrative Simplification

- **Security Rule-April 21, 2005**
  - **Designed to protect:**
    - **Confidentiality**
    - **Integrity**
    - **Availability**

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Administrative Simplification

- **Identifiers**
  - **National Employer Identifier**
  - **National Provider Identifier**
  - **National Health Plan Identifier**
  - **National Individual Identifier**

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Administrative Simplification

- **Centers for Medicare and Medicaid Services**
  - **www.cms.gov/hipaa/hipaa2/default.asp**
- **Office of Civil Rights**
  - **www.hhs.gov/ocr/index.html**
- **Washington Publishing Company**
  - **www.wpc-edi.com/hipaa/HIPAA_40.asp**
- **Workgroup for Electronic Data Interchange**
  - **www.wedi.org.**

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QUESTIONS?

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New Vision Care Billing Policy

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Objective

To briefly describe:

- **New Vision Care Billing Policy**
- **HIPAA Review & Approval Process**
- **New Provider Inquiry Policy**

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Agenda

- HIPAA Review and Approval Process
- New Vision Care Billing Policy
  - Overview
- CPT and HCPCS Crosswalk
- Claims Examples
  - Current Billing versus New Billing
- Transmittal Packet
  - How to read the Crosswalk Table
  - How to update your billing manual
- New Provider Inquiry Policy

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HIPAA Review & Approval Process

- **Six Step Process:**
  - **HIPAA Business Analyst Review**
  - **RHIA Analyst Review**
  - **Registered Nurse Review**
  - **MAA Subject Matter Expert Review**
  - **Local Code Set Committee Review**
  - **Approval by Interim Senior Deputy Director**

- **Result of Process:**
  - **MAA Transmittal Letter**

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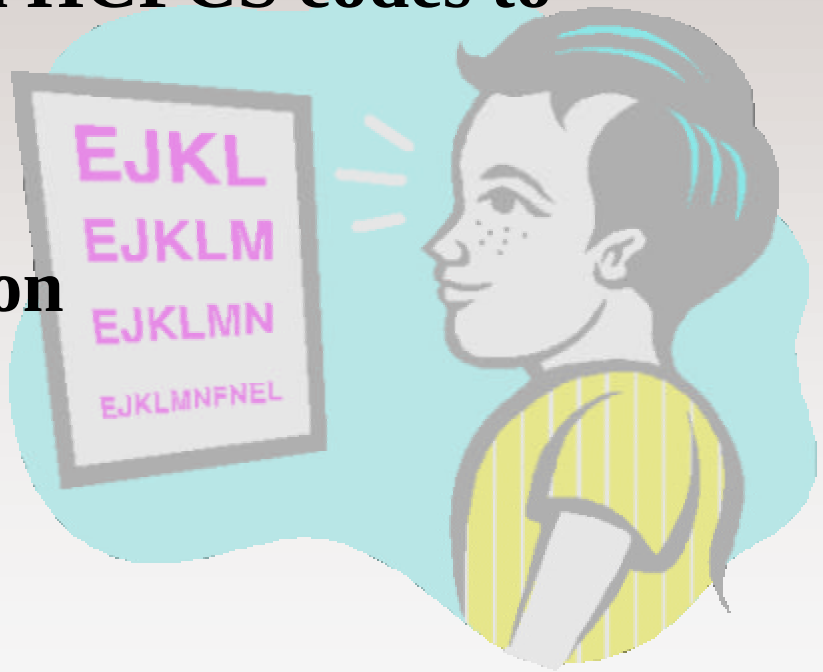
New Vision Care Billing Policy

- **Overview:**
  - **Effective date: August 1, 2003**
  - **Use standard CPT and HCPCS codes to bill claims**
  - **Do not attach outside lab/provider fabrication invoice to claim**
  - **Keep invoices on file**



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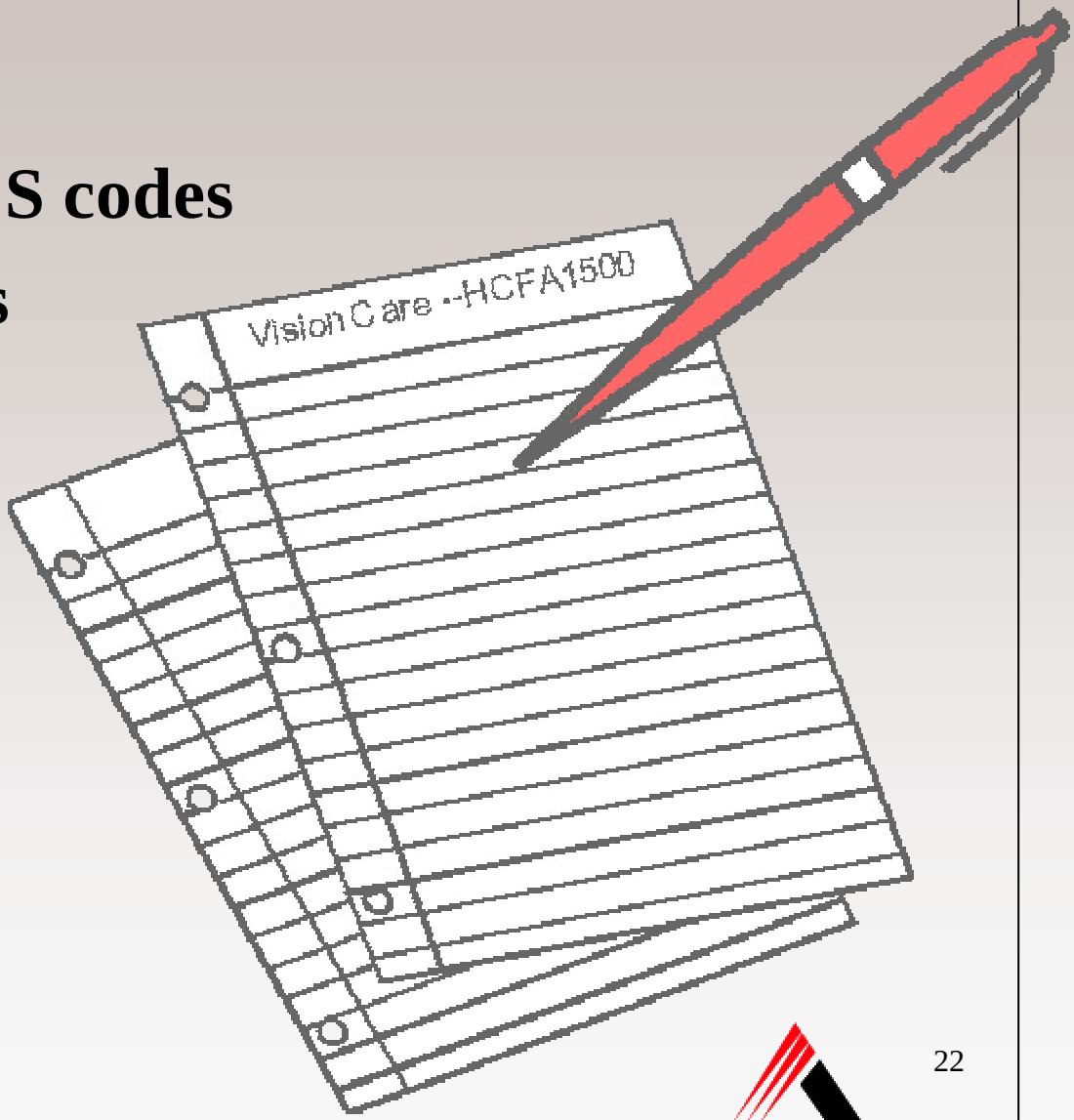
New Vision Care Billing Policy

- **CPT and HCPCS codes**
  - **Examinations**
  - **Fittings**
  - **Frames**
  - **Lenses**



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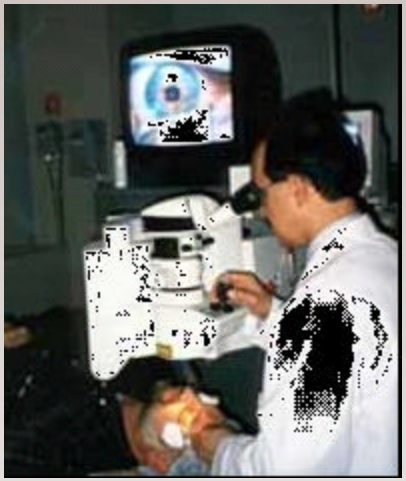
CPT and HCPCS Crosswalk: Exams

Current Code → Standard Code



- **Opticians & Optometrists:**
  - **Y2005 → 92015 –52**
  - **Y2006 → 92015**
- **Ophthalmologists**
  - **Y2005 → 92002, 92012, & 92014**

- **Code Definitions:**
  - **Y2005 – visual examination (refraction)**
  - **Y2006 – comprehensive exam**
  - **92015 – determination of refractive state**
  - **92002 – intermediate, new patient**
  - **92012 – intermediate, established patient**
  - **92014 – comprehensive, established patient, one or more visits**

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New Vision Care Billing Policy: Fittings

- **Repair/refittings**
  - **<u>Current Code → Standard Code</u>**
  - **Y2327 → 92370, 92371**

  - **Code Definitions:**
    - **Y2327 – service payment for replacement and or major repairs replacing lenses, templates or face plates, etc., adjusting them to the patient's face, including subsequent adjustments**
    - **92370 - repair/refit**
    - **92371 - repair/refit w/ prosthesis for aphakia**

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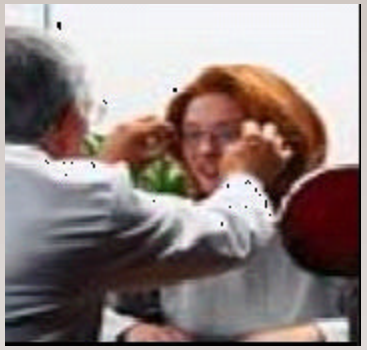
New Vision Care Billing Policy: Fittings

- **Lab Fabrication or Provider Fabrication:**
  - **Current Code → Standard Code**
  - **Y2340 or Y2344 → 92340**
  - **Y2341 or Y2345 → 92341**
  - **Y2342 or Y2346 → 92342**



  - **Code Definitions:**
    - **Y2340 - single vision services, fabricated by wholesale lab**
    - **Y2341 - bifocal vision services, fabricated by wholesale lab**
    - **Y2342 - trifocal vision services, fabricated by wholesale lab**
    - **Y2344 - single vision services, fabricated by provider**
    - **Y2345 - bifocal vision services, fabricated by provider**
    - **Y2346 - trifocal vision services, fabricated by provider**
    - **92340 - monofocal provider or lab fabricated**
    - **92341 - bifocal provider or lab fabricated**
    - **92342 - trifocal provider or lab fabricated**

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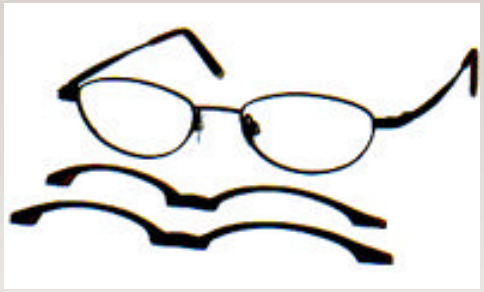
CPT and HCPCS Crosswalk: Frames

- **Frames - Single, Bifocal, & Trifocal**
  - **Current Policy:**
    - **Attach Invoice/Prescription to claim**
  - **New policy:**
    - **No Attachment**
    - **Standard Code: V2020**



    - **Code Definition:**
      - **V2020 - frames, purchases**

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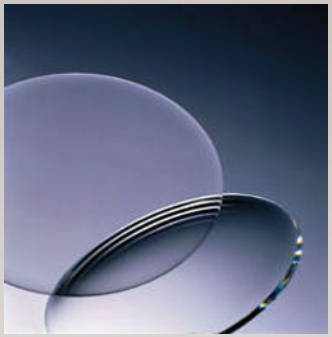
CPT and HCPCS Crosswalk: Lenses



- Lenses
  - Current Policy:
    - Attach Invoice/Prescription to claim
  - New Policy:
    - No attachment
    - Use standard codes for each lens type:
      - Single: V2100-V2199, and/or V2410
      - Bifocal: V2200-V2299, and/or V2430
      - Trifocal: V2300-V2399, and/or V2499
      - Contact Lenses: 92310

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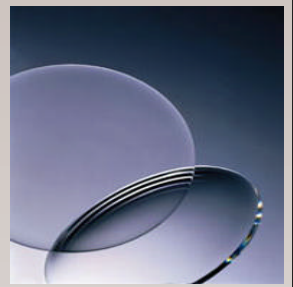
CPT and HCPCS Crosswalk: Lenses



- **Contact Lenses**
  - **No Change in policy:**
    - **Continue to obtain Prior Authorization**
    - **Continue to use Standard Code: 92310**

- **Code Definition:**
  - **92310 - Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia)**

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Claims Examples

1. **Lenses/Frames with Laboratory Fabrication**
2. **Lenses/Frames with Provider Fabrication**
3. **Lenses/Frames with Provider Fabrication including an Exam**

- **Real claims that are:**
  - **PHI de-identified**
  - **Selected examples**
  - **Use provider billed charges (no relationship to current or new rates)**

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Current Billing Frames & Lenses - Laboratory Fabrication

PLEASE DO NOT STAPLE IN THIS AREA

MEDICAID-DC
P.O. BOX 34768
ACS ATTN: CLAIMS DEPT.
WASHINGTON,DC 20043

[redacted]

APPROVED OMB-0938-0008

103

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER [redacted] (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [redacted]

3. PATIENT'S BIRTH DATE [redacted] SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial) [redacted]

5. PATIENT'S ADDRESS (No., Street) [redacted]

6. PATIENT RELATIONSHIP TO INSURED Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street) [redacted]

CITY [redacted] STATE DC

8. PATIENT STATUS Single X | Married | Other | Employed | Full-Time Student | Part-Time Student

CITY [redacted] STATE DC

ZIP CODE [redacted] TELEPHONE (Include Area Code) [redacted]

ZIP CODE [redacted] TELEPHONE (INCLUDE AREA CODE) [redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 07/12/2002

'NSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? X YES NO $ CHARGES 50.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. [redacted] 3. [redacted]

2. [redacted] 4. [redacted]

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 12042001	12042001	11		Y2340		1	63 60	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER [redacted] SSN EIN

26. PATIENT'S ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 6360

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 63.60

31. [redacted] SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) [redacted]

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE [redacted] PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

1

[redacted]

Custom Optical Lab

DATE PROMISED PATIENT

For [redacted] WASHINGTON, D.C.

Rx No.

ARRIVAL DATE 12 4 01 | TRAY NO. | BILLING DATE | INVOICE NO.

PATIENT [redacted]

	SPHL	CYL.	AXIS	DECENTRATION	PRISM
Distance R	75	+25	90		
Distance L	50	+25	95		
Add of Reading R					
Add of Reading L					

SEGMENT DIMENSIONS

	Height	Width	Inset
R	M/M	M/M	M/M
L	M/M	M/M	M/M

CIRCLE STYLE WANTED

BIFOCAL: ULTEX A, OTHER B | UNIVIS D | EXEC BIFOCAL | ORTH D F TILLYER D | FULL VUE | FAN OPTIC | OTHER BIFOCAL

TRIFOCAL (STRAIGHT STYLE)

TOTAL

ENCUT FOR:

LENS FOR:

CASE HARDEN | CROSS HARDEN | OTHER LENS DETAIL

STYLE, SIZE & COLOR OF FRAME OR MOUNTING: Parisian 31 GN 5x12

LENS INSTRUCTIONS: CORRECTIVE CURVE | FLAT | CRUXITE A AX | SOFT-LITE A B | RAYBAN 3 3 | CALOBAR B C 3 | COSMETAN | TRUE COLOR | 0 - 88 | TO - 38 | OTHER TINTS

LENSES	30	R
FR. MTG.	20	L
REPAIR		
CASE		
MISC.		
TOTAL	50	R

BOX OF BRIDGE | PANTO. POSITS 00 | BOX OF TEMPLES LB | TYPE OF TEMPLES LO | BENDING INSTRUCTIONS HOLES PER LENS 1

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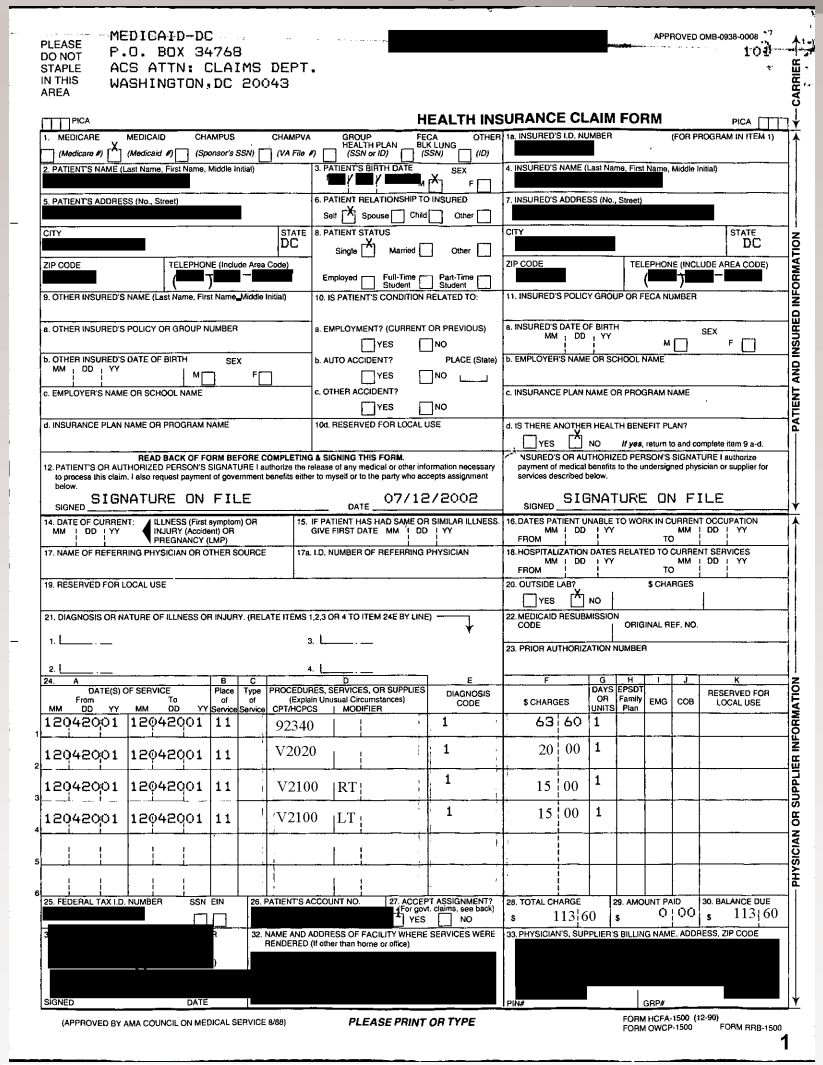
New Billing Frames & Lenses - Laboratory Fabrication



PLEASE DO NOT STAPLE IN THIS AREA

MEDICAID-DC
P.O. BOX 34768
ACS ATTN: CLAIMS DEPT.
WASHINGTON,DC 20043

[redacted]

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER [redacted] (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [redacted]

3. PATIENT'S BIRTH DATE [redacted] SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial) [redacted]

5. PATIENT'S ADDRESS (No., Street) [redacted]

6. PATIENT RELATIONSHIP TO INSURED Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street) [redacted]

CITY [redacted] STATE DC

8. PATIENT STATUS Single X | Married | Other | Employed | Full-Time Student | Part-Time Student

CITY [redacted] STATE DC

ZIP CODE [redacted] TELEPHONE (Include Area Code) [redacted]

ZIP CODE [redacted] TELEPHONE (INCLUDE AREA CODE) [redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M | F

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO X If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO X $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 2. 3. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 12042001	12042001	11		92340		1	63 60	1				
2 12042001	12042001	11		V2020		1	20 00	1				
3 12042001	12042001	11		V2100	RT	1	15 00	1				
4 12042001	12042001	11		V2100	LT	1	15 00	1				
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN [redacted]

26. PATIENT'S ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES | NO

28. TOTAL CHARGE $ 113 60

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 113 60

31. SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) [redacted]

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE [redacted]

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

1

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

No Laboratory Invoice Attachment Needed (Keep on file)

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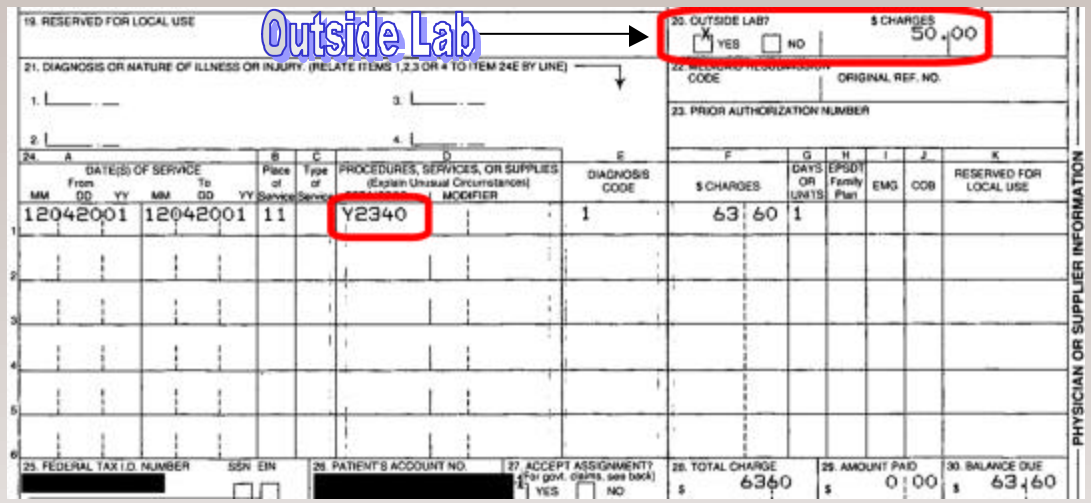
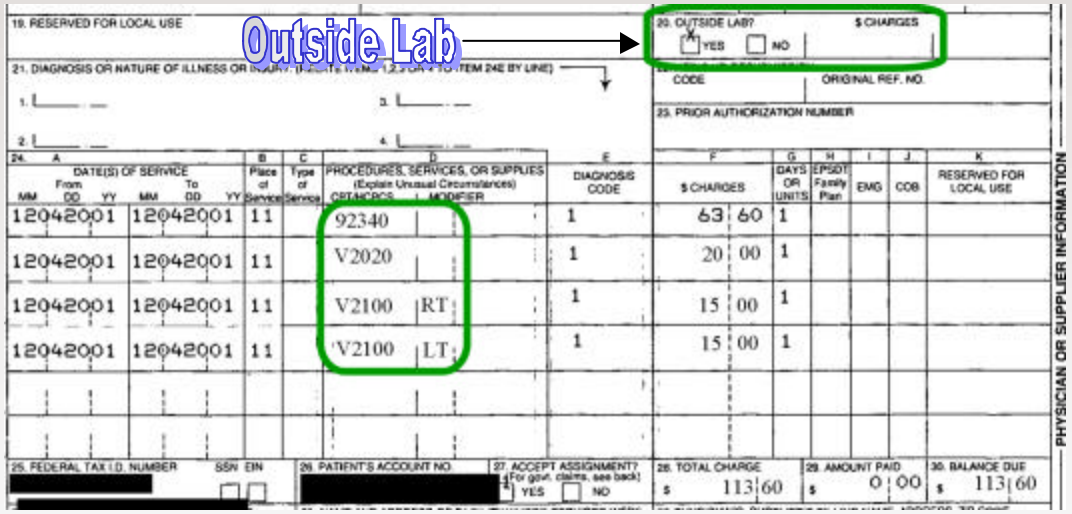
Current vs. New Frames & Lenses - Laboratory Fabrication

Current
Local Codes



Standard Codes
Starting
August 1, 2003



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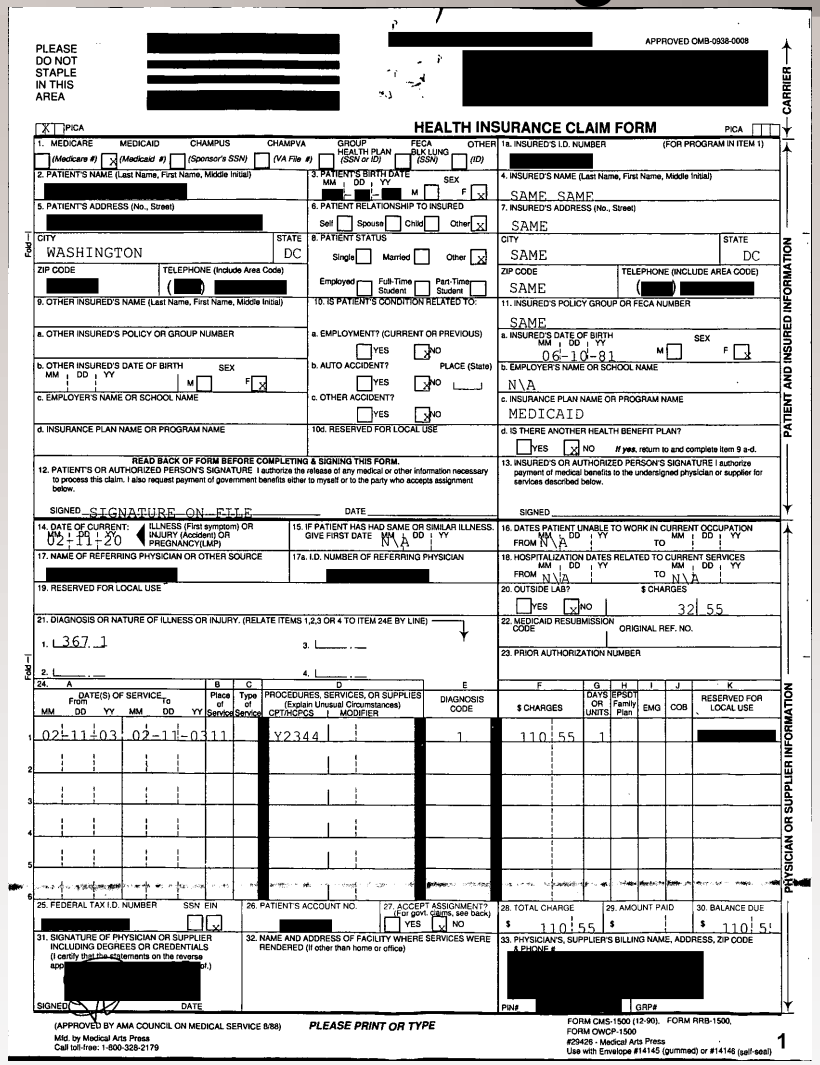
Current Billing Lenses/Frames - Provider Fabrication



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APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

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1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted]

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME SAME

5. PATIENT'S ADDRESS (No., Street): [redacted]

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other X

7. INSURED'S ADDRESS (No., Street): SAME

CITY: WASHINGTON — STATE: DC

8. PATIENT STATUS: Single Married Other X; Employed Full-Time Student Part-Time Student

CITY: SAME — STATE: DC

ZIP CODE: [redacted] — TELEPHONE (Include Area Code): ( ) [redacted]

ZIP CODE: SAME — TELEPHONE (INCLUDE AREA CODE): ( ) [redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: SAME

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY: 06-10-81 SEX M F X

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M F X

b. AUTO ACCIDENT? YES NO X PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME: N\A

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICAID

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY 02-11-20 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY N\A

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM N\A TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: [redacted]

17a. I.D. NUMBER OF REFERRING PHYSICIAN: [redacted]

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM N\A TO N\A

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO X $ CHARGES 32 55

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 367.1 2. 3. 4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02-11-03	02-11-0311	[redacted]	[redacted]	Y2344		1	110 55	1				
2												
3												
4												
5												
6												

PATIENT AND INSURED INFORMATION

25. FEDERAL TAX I.D. NUMBER: [redacted] SSN EIN X

26. PATIENT'S ACCOUNT NO.: [redacted]

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO

28. TOTAL CHARGE $ 110 55

29. AMOUNT PAID $

30. BALANCE DUE $ 110 55

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED [redacted] DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # [redacted]

PIN# [redacted] GRP#

PHYSICIAN OR SUPPLIER INFORMATION

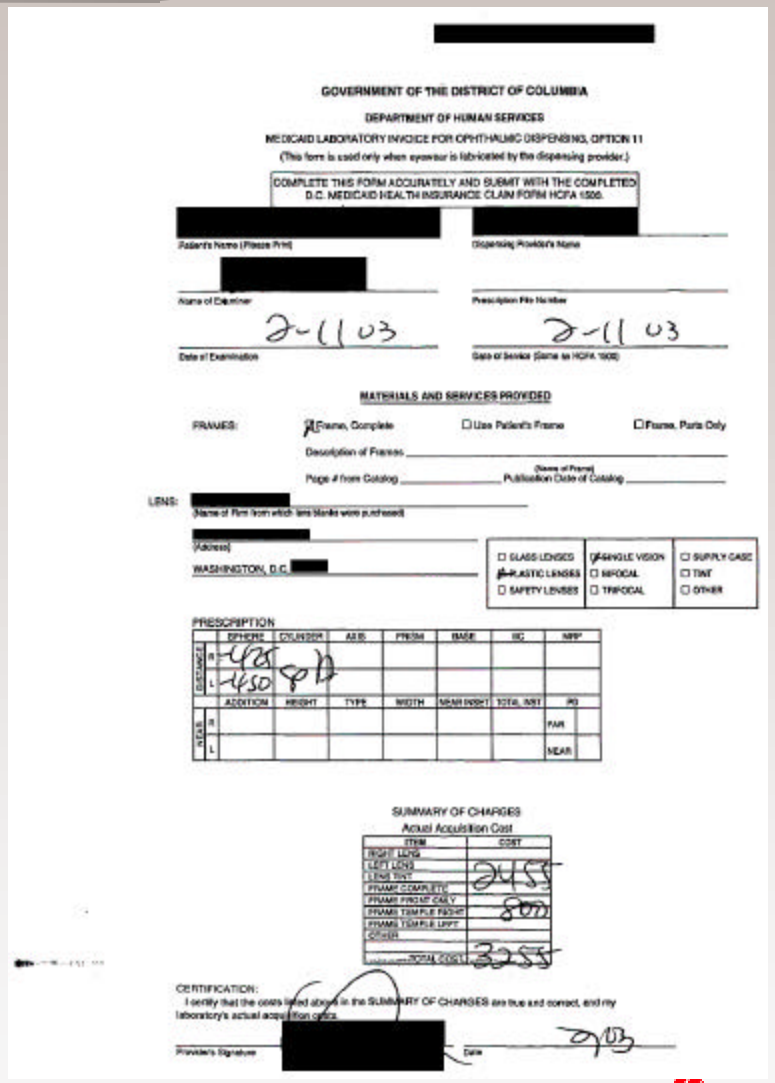
(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

Mfd. by Medical Arts Press
Call toll-free: 1-800-328-2179

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90). FORM RRB-1500, FORM OWCP-1500
#20426 - Medical Arts Press
Use with Envelope #14145 (gummed) or #14146 (self-seal)

1



[redacted]

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HUMAN SERVICES

MEDICAID LABORATORY INVOICE FOR OPHTHALMIC DISPENSING, OPTION 11

(This form is used only when eyewear is fabricated by the dispensing provider.)

COMPLETE THIS FORM ACCURATELY AND SUBMIT WITH THE COMPLETED D.C. MEDICAID HEALTH INSURANCE CLAIM FORM HCFA 1500.

[redacted] Patient's Name (Please Print) [redacted] Dispensing Provider's Name

[redacted] Name of Examiner — Prescription File Number

2-11 03 Date of Examination — 2-11 03 Date of Service (Same as HCFA 1500)

MATERIALS AND SERVICES PROVIDED

FRAMES: X Frame, Complete ☐ Uses Patient's Frame ☐ Frame, Parts Only

Description of Frames _____ (Name of Frame)

Page # from Catalog _____ Publication Date of Catalog _____

LENS: [redacted] (Name of Firm from which lens blanks were purchased)

[redacted] (Address)

WASHINGTON, D.C. [redacted]

☐ GLASS LENSES ☐ PLASTIC LENSES ☐ SAFETY LENSES

☐ SINGLE VISION ☐ BIFOCAL ☐ TRIFOCAL

☐ SUPPLY CASE ☐ TINT ☐ OTHER

PRESCRIPTION

	SPHERE	CYLINDER	AXIS	PRISM	BASE	OC	NRP
DISTANCE R	-4.25	SPH					
DISTANCE L	-4.50	SPH					
	ADDITION	HEIGHT	TYPE	WIDTH	SEGMENT	TOTAL WIDTH	PD
NEAR R							FAR
NEAR L							NEAR

SUMMARY OF CHARGES

Actual Acquisition Cost

ITEM	COST
RIGHT LENS	
LEFT LENS	24.50
LENS PAIR	
FRAME COMPLETE	
FRAME FRONT ONLY	8.00
FRAME TEMPLE RIGHT	
FRAME TEMPLE LEFT	
OTHER	
TOTAL COST	32.50

CERTIFICATION:

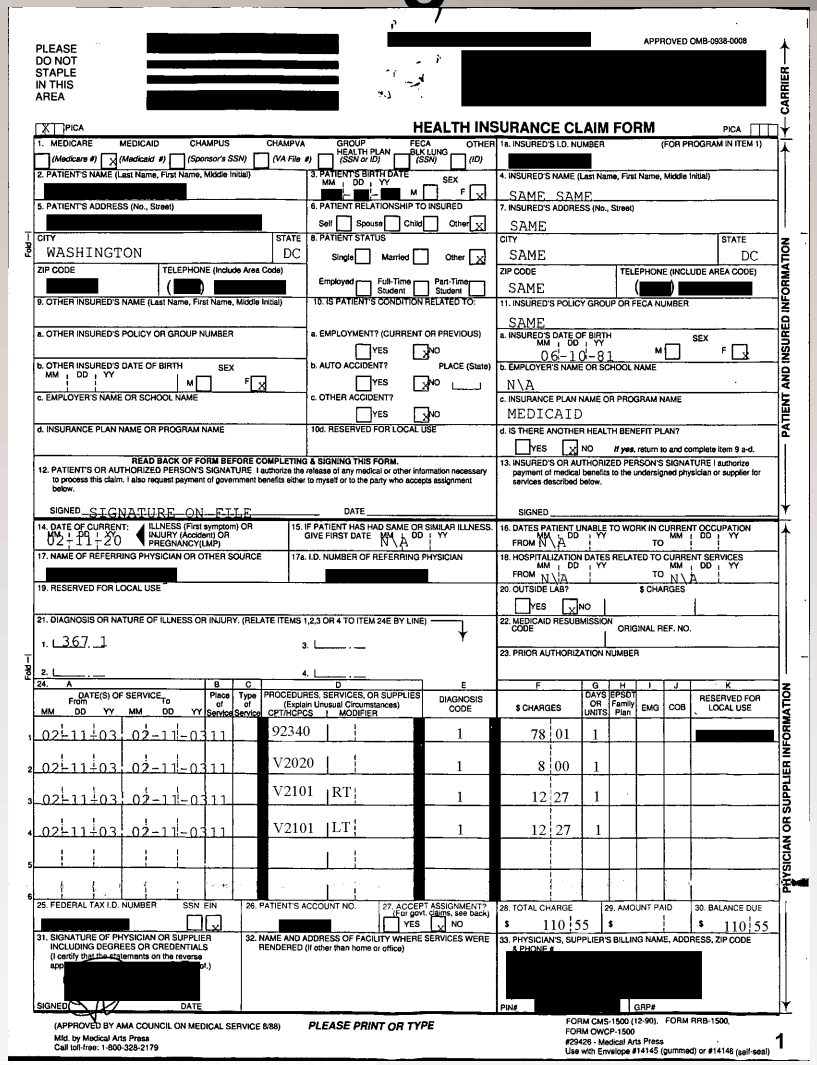
I certify that the costs listed above in the SUMMARY OF CHARGES are true and correct, and my laboratory's actual acquisition costs.

[redacted] Provider's Signature — 2/03 Date

DC Department of Health

ACS

New Billing Lenses/Frames - Provider Fabrication



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

X PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [redacted]

3. PATIENT'S BIRTH DATE [redacted] SEX M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME, SAME

5. PATIENT'S ADDRESS (No., Street) [redacted]

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other X

7. INSURED'S ADDRESS (No., Street) SAME

CITY WASHINGTON STATE DC

8. PATIENT STATUS Single | Married | Other X

CITY SAME STATE DC

ZIP CODE [redacted] TELEPHONE (Include Area Code) [redacted]

Employed | Full-Time Student | Part-Time Student

ZIP CODE SAME TELEPHONE (INCLUDE AREA CODE) [redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER SAME

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO X

a. INSURED'S DATE OF BIRTH 06-10-81 SEX M | F X

b. OTHER INSURED'S DATE OF BIRTH SEX M | F X

b. AUTO ACCIDENT? YES | NO X PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME N\A

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME MEDICAID

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO X If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY 02 11 20 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY N\A

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM N\A TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE [redacted]

17a. I.D. NUMBER OF REFERRING PHYSICIAN [redacted]

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM N\A TO MM DD YY N\A

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO X $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L367.1 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 11 03	02 11 03	11		92340		1	78 01	1				
2 02 11 03	02 11 03	11		V2020		1	8 00	1				
3 02 11 03	02 11 03	11		V2101	RT	1	12 27	1				
4 02 11 03	02 11 03	11		V2101	LT	1	12 27	1				
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN [redacted]

26. PATIENT'S ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO

28. TOTAL CHARGE $ 110 55

29. AMOUNT PAID $

30. BALANCE DUE $ 110 55

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) [redacted] SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # [redacted] PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90). FORM RRB-1500, FORM OWCP-1500 #29426 - Medical Arts Press Use with Envelope #14145 (gummed) or #14146 (self-seal)

Mfd. by Medical Arts Press Call toll-free: 1-800-328-2179

1

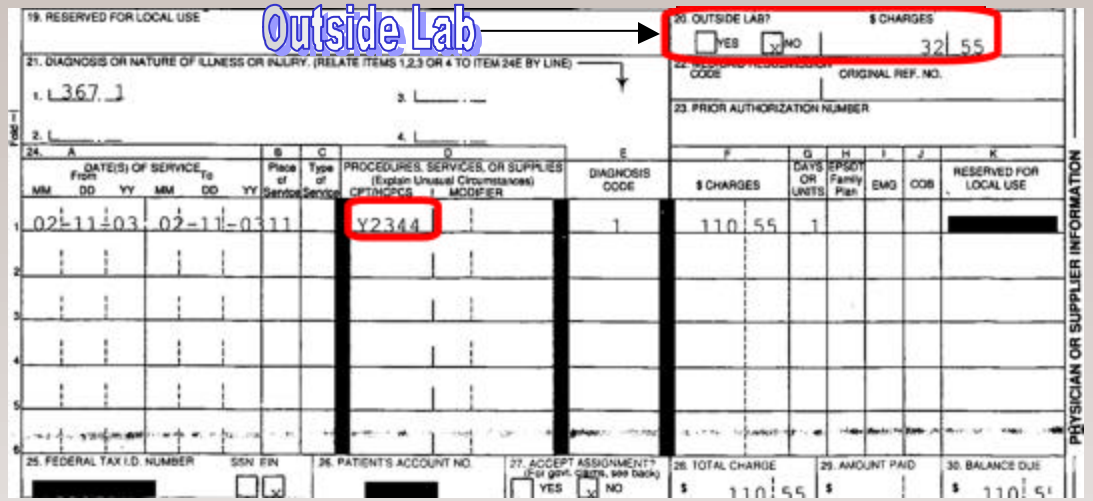
No Attachment Needed (Keep on file)

DC Department of Health

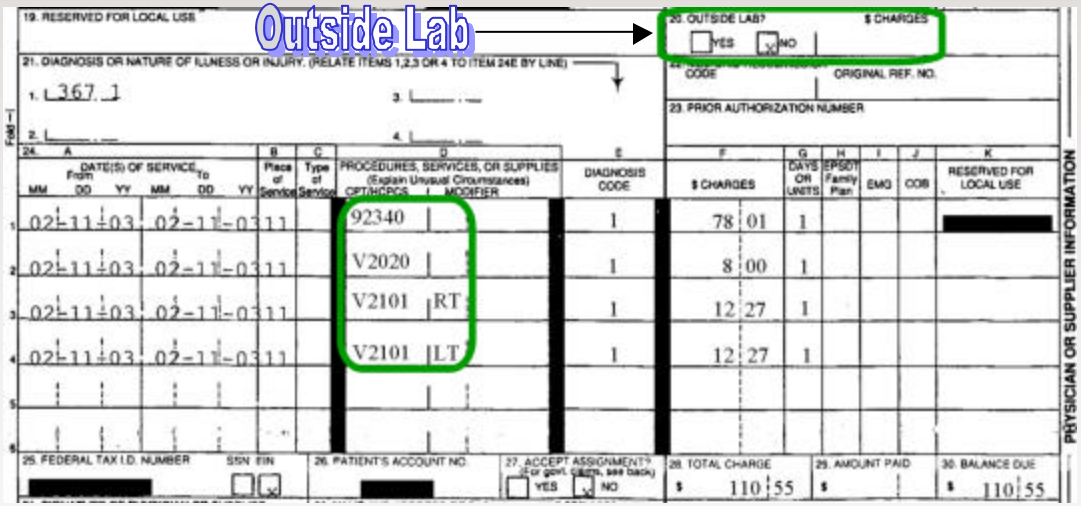
ACS

Current vs. New Lenses/Frames - Provider Fabrication

Current
Local Codes



Standard Codes
Starting
August 1, 2003



DC Department of Health

ACS

Current Billing Lenses/Frames - Provider Fabrication - Exam

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) ✓ | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [redacted]

3. PATIENT'S BIRTH DATE [redacted] SEX M ✓ F

4. INSURED'S NAME (Last Name, First Name, Middle Initial) [redacted]

5. PATIENT'S ADDRESS (No., Street) [redacted]

6. PATIENT RELATIONSHIP TO INSURED Self ✓ Spouse Child Other

7. INSURED'S ADDRESS (No., Street) [redacted]

CITY Washington STATE DC

8. PATIENT STATUS Single Married Other / Employed Full-Time Student Part-Time Student

CITY Washington STATE DC

ZIP CODE [redacted] TELEPHONE (Include Area Code) [redacted]

ZIP CODE [redacted] TELEPHONE (INCLUDE AREA CODE) [redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) None

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER Medicaid

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO ✓

a. INSURED'S DATE OF BIRTH [redacted] SEX M ✓ F

b. OTHER INSURED'S DATE OF BIRTH SEX M F

b. AUTO ACCIDENT? YES NO ✓ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO ✓

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ✓ If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED [redacted] DATE 04-04-03

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED [redacted]

14. DATE OF CURRENT: MM DD YY 04 04 03 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE [redacted]

17a. I.D. NUMBER OF REFERRING PHYSICIAN [redacted]

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO ✓ $ CHARGES 146 95

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. LV720
2. L3631
3. [redacted]
4. [redacted]

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 04 04 03	04 04 03	11		V2006		1	80 —					
2 04 04 03	04 04 03	11		V2345		2						
3 04 04 03	04 04 03	11		lab invoice attached		2	146 95					
4												
5												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER [redacted] SSN ✓ EIN

26. PATIENT'S ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 226 95

29. AMOUNT PAID $ -0-

30. BALANCE DUE $ 226 95

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

[redacted] 04-23-03 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED [redacted]

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE [redacted]

PIN# [redacted]

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

1

[redacted]

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES

MEDICAID LABORATORY INVOICE FOR OPTHALMIC DISPENSING, OPTION II
(This form is used only when eyewear is fabricated by the dispensing provider)

[redacted]

Patient's Name (Please Print) [redacted]

Dispensing Provider's Name [redacted]

Name of Examiner [redacted]

Prescription File Number

04-09-03
Date of Examination

04-04-03
Date of Service (Same as HCFA 1500)

MATERIALS AND SERVICES PROVIDED

FRAMES: ✓ Frame, Complete ☐ Use Patient's Frame ☐ Frame, Parts Only

Description of Frames: Welling Navigator 5516
(Name of Frame)

Page # from Catalog

LENS: [redacted]
(Name of Firm from which lens blanks were purchased)

Baltimore, MD
(Address)

☐ Glass Lenses ☐ Single Vision ✓ Supply Case
☐ Plastic Lenses ☐ Bifocal ☐ Tint
☐ Safety Lenses ☐ Trifocal ☐ Other

PRESCRIPTION

	SPHERE	CYLINDER	AXIS	PRISM	BC	DIA
DISTANCE R	+1.00	-1.50	16			
L	+1.25	-.75	135			
	ADDITION	TYPE	OCCUP.	NEAR PRISM	TOTAL PRISM	FH
NEAR R	2.00	FT	28	3in		68
L	2.00	FT	28	3in		63

SUMMARY OF CHARGES
Actual Acquisition Cost

ITEM	COST
RIGHT LENS	55.00
LEFT LENS	55.00
LEFT TINT	
FRAME COMPLETE	24.95
FRAME FRONT ONLY	
FRAME TEMPLE RIGHT	
FRAME TEMPLE LEFT	
OTHER (CASE)	2.00
TOTAL COST	146.95

(This amount must be entered into Block 20.)

CERTIFICATION:
I certify that the costs listed above in the SUMMARY OF CHARGES are true and correct, and my laboratory's actual acquisition cost.

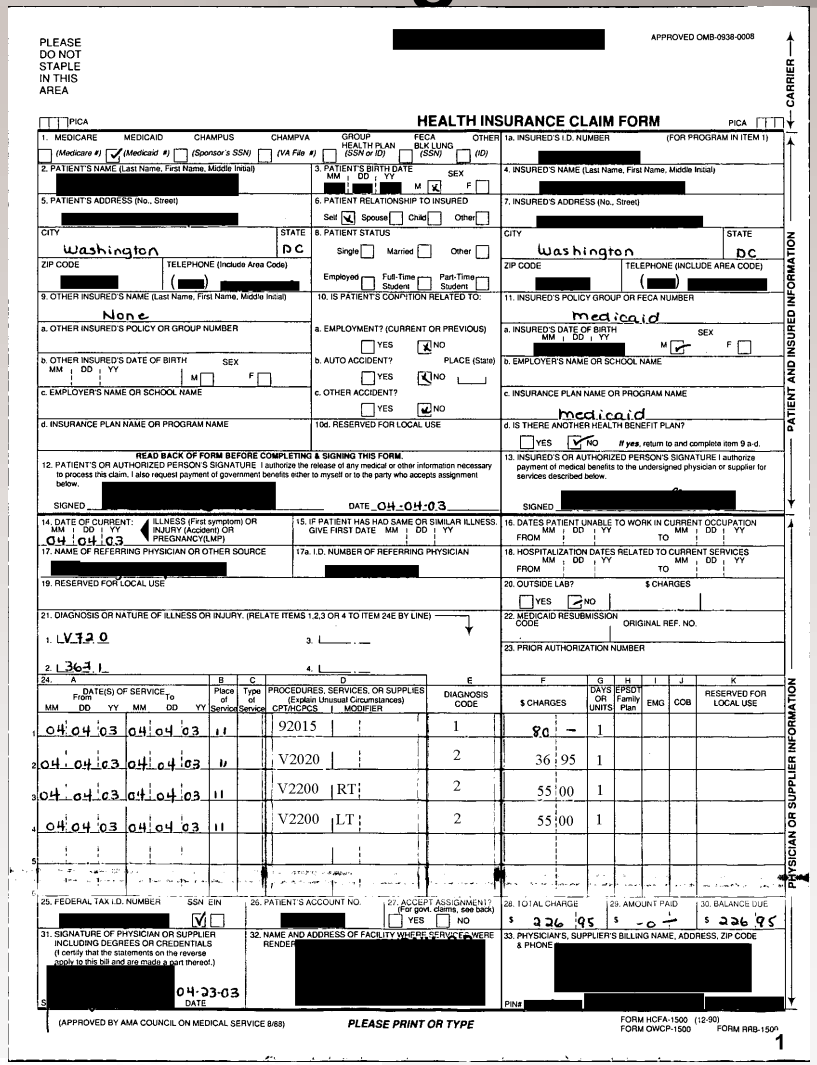
[redacted]
Provider's Signature

04-23-03
Date

DC Department of Health

ACS

New Billing Lenses/Frames - Provider Fabrication - Exam



PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) ☐ MEDICAID (Medicaid #) ☐ CHAMPUS (Sponsor's SSN) ☐ CHAMPVA (VA File #) ☐ GROUP HEALTH PLAN (SSN or ID) ☐ FECA BLK LUNG (SSN) ☐ OTHER (ID) ☐

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [redacted]

3. PATIENT'S BIRTH DATE MM DD YY [redacted] SEX M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial) [redacted]

5. PATIENT'S ADDRESS (No., Street) [redacted]

6. PATIENT RELATIONSHIP TO INSURED Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street) [redacted]

CITY [redacted] STATE DC

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY Washington STATE DC

ZIP CODE [redacted] TELEPHONE (Include Area Code) ( ) [redacted]

ZIP CODE [redacted] TELEPHONE (INCLUDE AREA CODE) ( ) [redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) None

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER Medicaid

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY [redacted] SEX M ☒ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME Medicaid

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED [redacted] DATE 04-04-03

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED [redacted]

14. DATE OF CURRENT: MM DD YY 04 04 03 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE [redacted]

17a. I.D. NUMBER OF REFERRING PHYSICIAN [redacted]

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. LV720 3. 2. L3631 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 04 04 03	04 04 03	11		92015		1	80 00	1				
2 04 04 03	04 04 03	11		V2020		2	36 95	1				
3 04 04 03	04 04 03	11		V2200	RT	2	55 00	1				
4 04 04 03	04 04 03	11		V2200	LT	2	55 00	1				
5												

25. FEDERAL TAX I.D. NUMBER [redacted] SSN EIN ☒ ☐

26. PATIENT'S ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $ 226 95

29. AMOUNT PAID $ -0-

30. BALANCE DUE $ 226 95

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) [redacted] 04-23-03 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED [redacted]

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE [redacted] PIN# [redacted]

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

1

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

No Attachment Needed (Keep on file)

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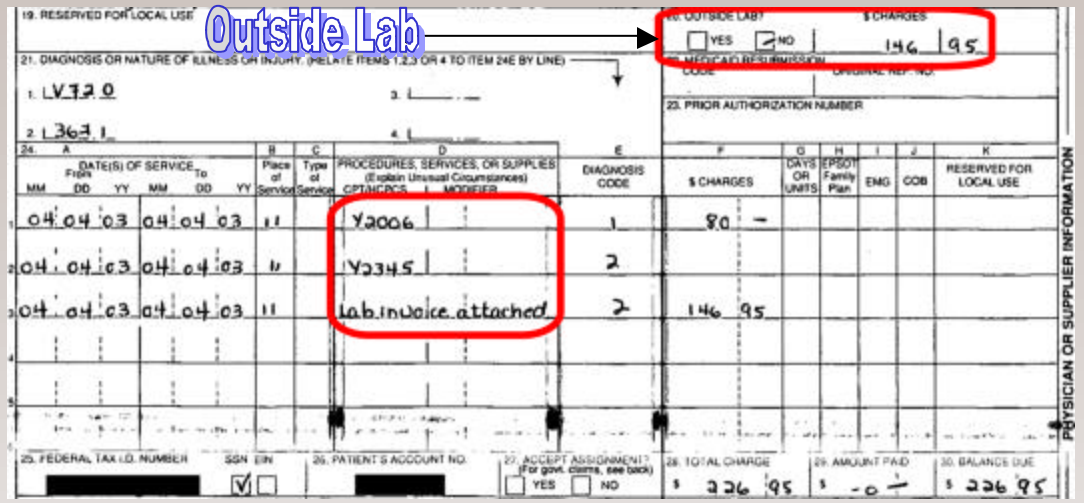
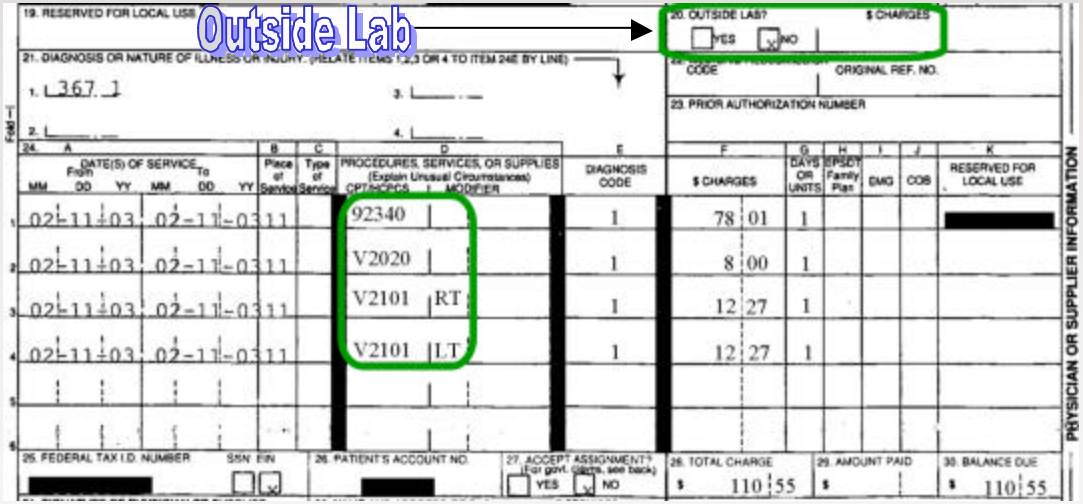
Current vs. New Lenses/Frames - Provider Fabrication - Exam

Current
Local Codes



Standard Codes
Starting
August 1, 2003



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New Vision Care Billing Policy - Summary

- **Transition Date: August 1, 2003**
- **Do not submit invoices/prescriptions as an attachment to your claim**
- **Keep invoices/prescriptions on file**
- **Use Standard Codes (refer to Crosswalk Table)**

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Transmittal Packet—Crosswalk Table

Local Code & Modifier Description	Standard Code Description	Medicaid Rates	Remarks
Y2005 VISUAL EXAMINATION - REFRACTION	92015 -52 Determination of refractive state. The examiner determines the prescription required by evaluating the effectiveness of a series of lenses through which the pt is asked to view an eye chart. Physician not required to be present. A prescription is issued, no fitting is done at this time.	No Pricing Change	Optician and optometrist will bill this code for visual examination.

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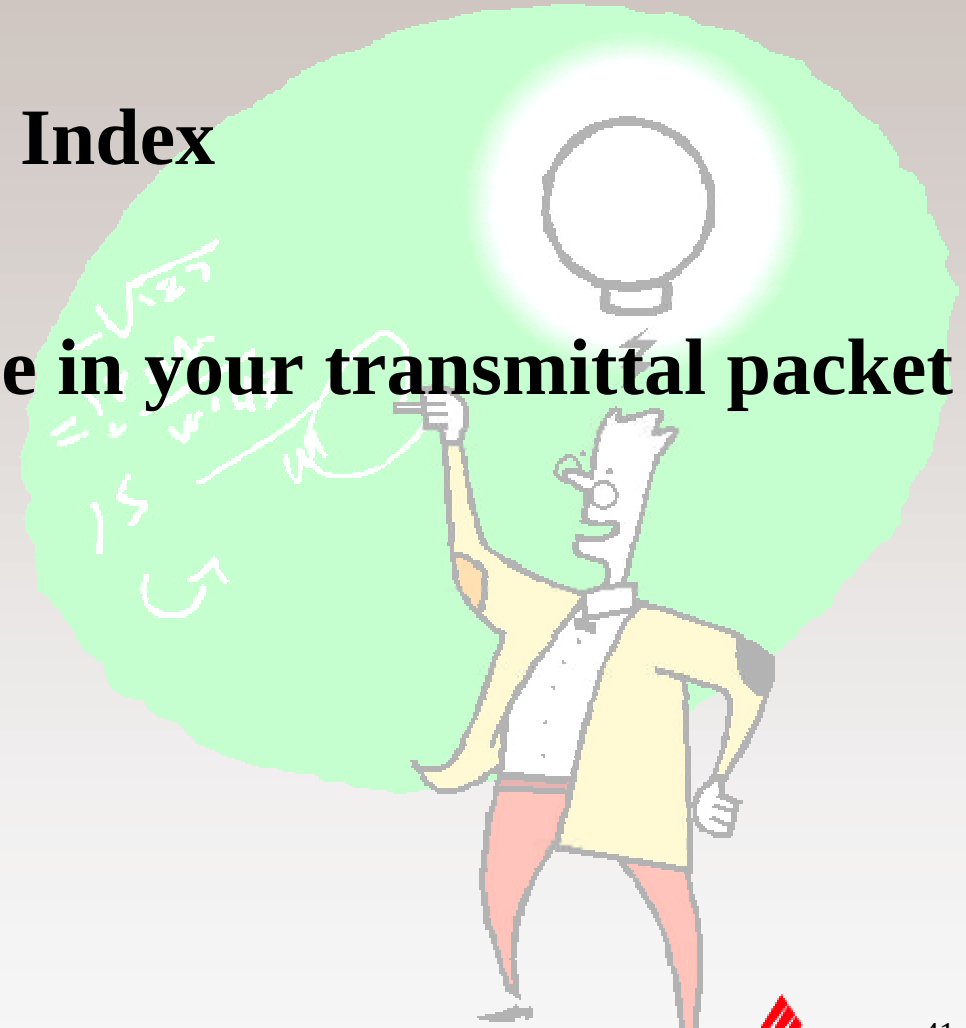
Transmittal Packet—Billing Manual

- **Added a Revision Index**
- **Updated pages are in your transmittal packet**



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Billing Manual Update - Revision Index

Revision Reference				
Section	**Remove Page**	**Insert Page**	**Revised Page(s)**	**Description of Change**
Billing Manual Cover Page	N/A	Not numbered	New	§ Added standard Billing Manual cover page.
Table of Contents	N/A	2-6	New	§ Added Table of Contents.
Table of Contents	N/A	7	New	§ Insert Revision Index page, Revised Date of 05/03/03.
Section 8.8	50	50	50	§ Added paragraph requesting provider name, tax id, provider Medicaid number, and name of person making call.
Section 13.5	68-69	68-69	68-69	§ Removed references to submitting attachments for Option I, Option II § Added instructions for billing frames, lenses, and fittings using standard HCPCS codes
Section 13.6	72	72	72	§ Removed references to submitting attachments for Option I, Option II § Added instructions for billing frames, lenses, and fittings using standard HCPCS codes
Section 13.8	85	85	85	§ Removed reference to Option I and Option II for Block 20.

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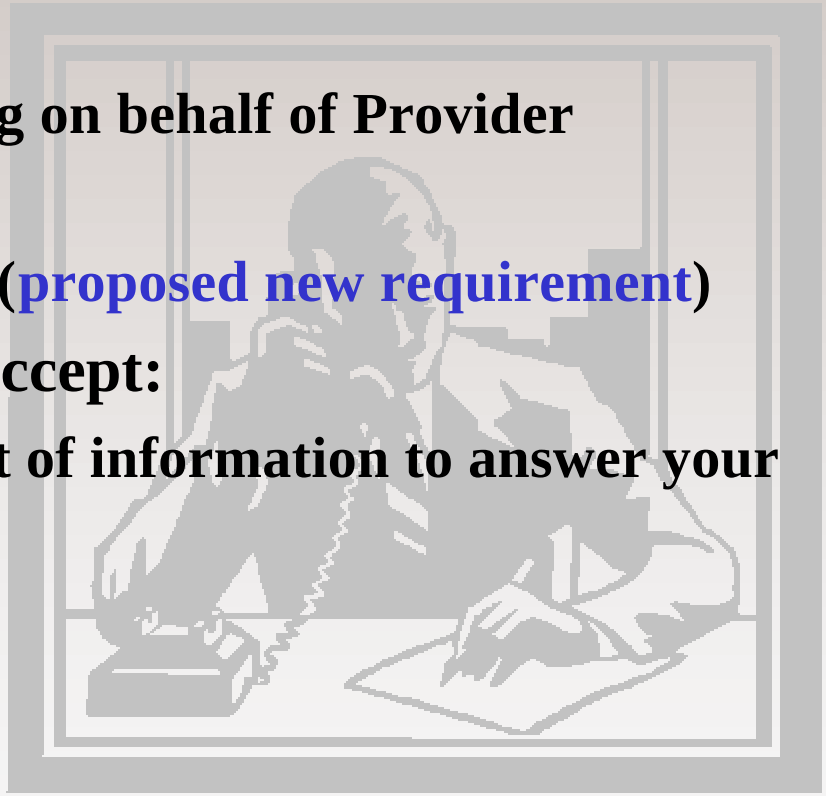
New Provider Inquiry Policy

- **When Calling the Provider Inquiry Unit**
  - **Please be prepared to provide:**
    - **Provider Name**
    - **Name of person calling on behalf of Provider**
    - **Medicaid Provider ID**
    - **Provider Tax ID/SSN (proposed new requirement)**
  - **Please be prepared to accept:**
    - **The minimum amount of information to answer your inquiry**



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Provider Inquiry Unit

- **Hours of operation:**
  - **Monday through Friday**
  - **8 A.M. until 5 P.M.**
- **Telephone number: (866) 752-9233**
- **Correspondence address:**
  - **ACS**
  - **Attention: Provider Inquiry Unit**
  - **P.O. Box 34734**
  - **Washington, DC 20043-4761**

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Provider Outreach Training Schedule

- **Introductory – June 9, 2003**
  - **Thank you, for attending today's training.** ☺
- **Detailed - June 16 – July 18, 2003**
  - **Electronic Claims Companion Guides**
- **Software - Aug 1 – Aug 31, 2003**
  - **WINASAP2003**

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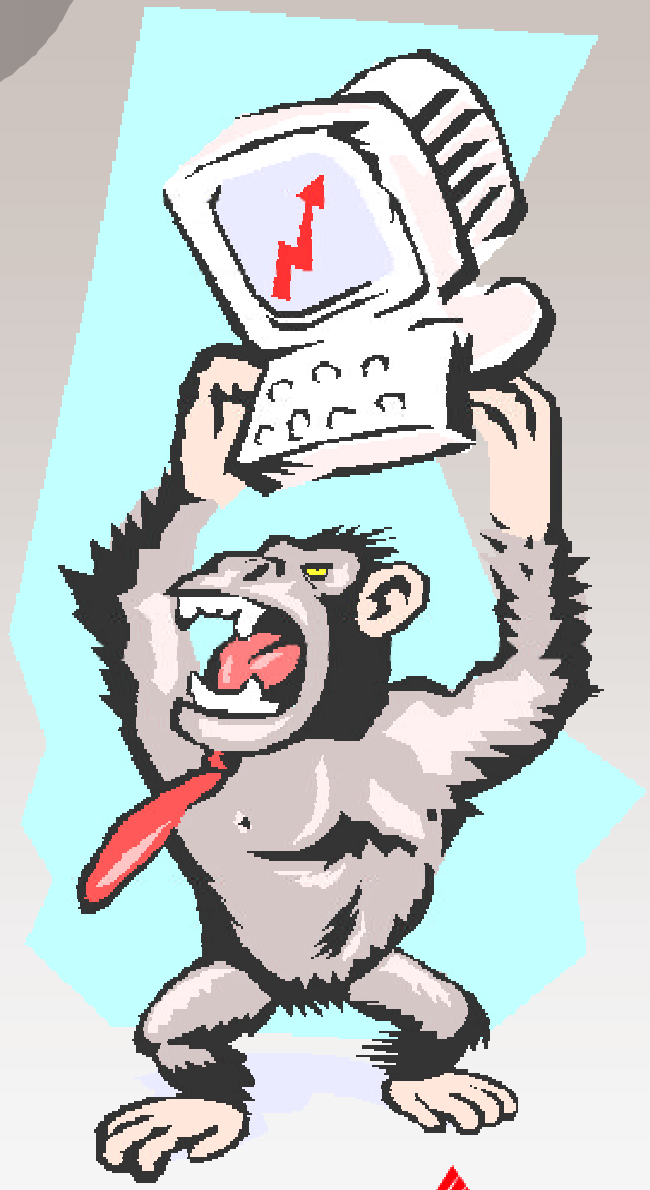
Questions?



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A C S

Electronic Data Interchange

ACS EDI Gateway, Inc.

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Purpose

- To provide an overview of
  - ACS EDI Gateway, Inc
    - Trading Partner Management
      - Enrollment process
      - Community outreach
      - EDI Support Unit

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Trading Partner Management

- **Enrollment Packets**
  - **Enroll through EDI Gateway, Inc. via:**
    - **EDI Enrollment Packet**
      - **Demographics and contact information**
      - **Submission methods**
      - **Transactions**
      - **Response Retrieval**
    - **Obtain via:**
      - **ACS EDI Support Unit at 866.775.8563, Monday through Friday, 8 a.m. to 5 p.m. EST**
      - **Download from website www.acs-gcro.com**

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Trading Partner Management

- **EDI Provider Enrollment Packet**
  - **Individual**
  - **Group**

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Trading Partner Management

- **EDI Submitter Enrollment Packet**
  - **Software Vendor**
  - **Billing Agent**
  - **Clearinghouse**

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Trading Partner Management

- Community Outreach
  - ACS EDI Gateway Business Analysts
    - Training
      - Services
      - Software
    - Research Issues
      - Format/reject related issue

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Trading Partner Management

- **Community Outreach**
  - **Companion Guides**
    - **Data clarification**
    - **ASC X12N Transaction Set Implementation Guides**
  - **Testing**
    - **Established testing strategy and process**
    - **Reduces number of invalid transactions**
    - **Mitigates fraud and abuse risk**
    - **Approved vendors**

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Trading Partner Management

- **Community Outreach**
  - **ACS EDI Gateway Support Unit**
    - **Technical assistance with software, hardware, and transmission issues**
    - **Data Exchange Services**
    - **Informational Services**
    - **Enrollment of submitters**
    - **866.775.8563, Monday through Friday, 8 a.m. to 5 p.m. EST**

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Trading Partner Management

- Call ACS EDI Support Unit
  - 866.775.8563
    - Request ACS EDI Gateway Trading Partner Enrollment Packets
    - Verify status of EDI Trading Partner Enrollment Forms
    - Request logon information
    - Verifying confirmation receipt for electronic claims submission

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Trading Partner Management

- Call ACS EDI Support Unit
  - 866.775.8563
    - Download, install, and train on WINASAP2003 software
    - Retrieve electronic responses via iDEx
    - Remedy electronic transmission difficulties

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Trading Partner Management

- When to call Provider Inquiry
  - 866.752.9233
    - Billing questions related to policy
    - Electronic Funds Transfer (EFT)
    - Paper claims processing
    - Medicaid program enrollment

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QUESTIONS?

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This presentation may contain "forward-looking statements" within the meaning of the Private Securities Litigation Reform Act of 1995. These statements are subject to numerous risks and uncertainties, many of which are outside the Company's control. As such, no assurance can be given that the actual events and results will not be materially different than the anticipated results described in the forward-looking statements. Factors could cause actual results to differ materially from such forward-looking statements. For a description of these factors, see the Company's prior filings with the Securities and Exchange Commission, including the most recent Form 10-K. ACS disclaims any intention or obligation to revise any forward-looking statements, whether as a result of new information, future event, or otherwise.

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